State of Idaho

Legislative Services Office

Management Report

A communication to the Joint Finance-Appropriations Committee

IDAHO DEPARTMENT OF HEALTH AND WELFARE

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Report IC27006

Serving Idaho's Citizen Legislature

LEGISLATIVE AUDITS' MANAGEMENT REPORT

DEPARTMENT OF HEALTH AND WELFARE

PURPOSE AND SCOPE. In planning and performing our audit of the statewide *Single Audit* report for the State of Idaho for the fiscal year ended June 30, 2006, we completed certain financial audit procedures on the Idaho Department of Health and Welfare's financial activities that occurred during the fiscal year. The scope of work was limited to the Department's federal major programs as determined for the statewide *Single Audit*. Therefore, we considered the internal control structure to determine appropriate procedures and required tests, along with procedures performed at other State agencies, that would allow us to express our opinion on the statewide *Single Audit* and not to provide assurance on the Department's internal control.

CONCLUSION. Although we include ten findings and recommendations in this report, we conclude that the financial operations of the Department meet accepted standards, and that the Department substantially complies with laws, regulations, rules, grants, and contracts for which we tested compliance.

FINDINGS AND RECOMMENDATIONS. The ten findings and recommendations presented below relate to the program indicated.

FINDING #1
CFDA Title: Medicaid
CFDA #: 93.778
Federal Award #: 05-0505ID5028
Program Year: October 1, 2004 to September 30, 2005
Federal Agency: Department of Health and Human Services
Compliance Requirement: N – Special Tests
Questioned Costs: Not determinable

The Medicaid program has not coordinated the efforts to recover benefit costs through the Child Support Program as required.

Federal regulation (42 CFR 433.151) requires the State Medicaid program to establish an agreement with the State Child Support Program to coordinate the recovery of benefit costs from non-custodial parents and other third parties. The Medicaid program is required to pay the administrative expenses that are not otherwise allowable under the federal Child Support Grant and to pay an incentive to the State program equal to 15% of the amounts recovered. This incentive amount is paid entirely from the federal share of the recoveries.

The State Medicaid Plan indicates that the required agreement exists with the Child Support Program, but a copy of this document could not be located by the Department. In addition, we found no evidence that the Medicaid program had ever paid the Child Support Program for expenses to recover benefit costs or the 15% incentive of the amounts recovered.

The Child Support Program has actively pursued the recovery of Medicaid birth costs over the past three years, as a result of prior audit recommendations. During this period, the Child Support Program has recovered the following amounts:

FY 04	$2,585,492
FY 05	2,448,225
FY 06	1,570,510

Collections have declined during the past year due to instructions from the federal child support grantor that the administrative expenses to recover Medicaid benefit costs are unallowable. Therefore, the Child Support Program discontinued its efforts to recover these amounts due to a lack of funding, not knowing that the expenses for these efforts were reimbursable from the Medicaid program. The incentive payment could also have provided nearly $1 million over the past three years in additional funds to enhance the Child Support Program's efforts.

RECOMMENDATION #1

We recommend that the Department establish a new cooperative agreement between the Medicaid and the Child Support Programs that meets the requirements of federal regulations. We also recommend that the Department investigate whether prior period costs for services and incentives are recoverable from the Medicaid program by the Child Support Program.

CORRECTIVE ACTION PLAN

The cooperative agreement between Medicaid and Child Support has been drafted and is currently being reviewed by Medicaid to ensure it meets the requirements of federal regulation. The Child Support Program is investigating whether prior period costs for Medicaid services and incentives can be recovered from the Medicaid Program.

FINDING #2
CFDA Title: Medicaid
CFDA #: 93.778
Federal Award #: 05-0505ID5028
Program Year: October 1, 2004 to September 30, 2005
Federal Agency: Department of Health and Human Services
Compliance Requirement: E – Eligibility
Questioned Costs: Not determinable

Medicaid eligibility for newborn children is mistakenly ended early or not established at all.

The State is required by federal regulation to develop Medicaid eligibility criteria and incorporate the criteria into the State Plan. The criteria for a child born to a poverty level woman is further defined in administrative rule (IDAPA 16.03.01.601), and requires that the child remain Medicaid eligible for one year from date of birth. Other than a loss of residency, all other eligibility criteria for a newborn child are not applied until the annual renewal is completed.

We included a random sample of 68 (from a total of nearly 10,000) newborn children in our test for eligibility paid for by Medicaid during calendar year 2005. Our tests showed that eligibility was ended early, in error, for 7 newborn children (10%), and 3 others (4%) did not have eligibility established at all. The most common reason for ending eligibility was "failure to complete redetermination;" however, such action is not required for newborn children through their first 12 months. The reasons for failing to establish eligibility were not clear; however, the complexity of the processes and control weaknesses inherent in the EPICS eligibility system are contributing factors.

The Department uses ad-hoc reports from the EPICS system to address a variety of issues, including newborn children whose eligibility has mistakenly ended early. These reports are either not produced or worked each month, and efforts to identify newborn children who are not made eligible has not been fully developed.

Based on the results of our sample, we estimate that more than 1,500 newborn children had their eligibility ended early or not established at all during calendar 2005. This situation is contrary to the State Plan and creates a situation whereby vulnerable newborn children are denied access to medical care.

RECOMMENDATION #2

We recommend that the Department establish procedures to ensure all children born to poverty level women remain eligible for one year from date of birth as required by the State Plan. These procedures should include creating and working ad-hoc reports each month that identify newborn children whose eligibility has ended early and those whose eligibility was not properly established. We also recommend that the Department provide staff with additional training to reduce errors in establishing and maintaining newborn eligibility.

CORRECTIVE ACTION PLAN

The problem of early closure of children under one year of age who were born to a Medicaid qualifying mother is created by a number of factors. However, there are some situations where a child under one year of age does not have automatic eligibility for one year, for example:

1. If the mother was not on Medicaid at the time of the birth.
2. If the household requests closure.
3. If the household leaves the state.
4. If the child is adopted.

The issue of children not being added to the Medicaid case at all is very difficult to address. The Division adds a child to a case as soon as it is reported by the parent or by a hospital or doctor. Many times the birth of a child is not reported until medical bills are denied, the family has another change, an eligibility redetermination occurs, or it is not reported at all. An alert is generated in the automated system that tells a worker when a child is more than two months past due.

To address early closure of Medicaid for children who should remain eligible continuously for one year the Division has:

1. Consolidated all Family Medicaid Maintenance into one statewide unit. This groups works only Family Medicaid related cases and has specific training in this area.
2. A regular monthly report of all children under one year of age who were closed is generated to field managers who have workers validate the closure and report back to the manager.
3. A workload management report is generated to field workers of Family Medicaid cases that have a child under one year of age at the time an eligibility redetermination is due. Family Medicaid staff can use this report to target these cases to ensure the manual actions required to keep the child open are taken.
4. The Family Medicaid Consolidated Units have procedures in place to add newborns to Medicaid cases. An agreement was established with the hospitals to act on information received directly from the hospitals within two business days. This process has improved the accuracy and assurance of newborns added to the Medicaid cases timely.

The Division of Welfare believes we have taken acceptable action to avoid the early closure of children under one year of age who are automatically entitled to a full year of coverage. We will also monitor this corrective action plan through our quality assurance processes to ensure that the steps outlined in this plan lead to improvements in erroneous closures on children less than one year of age.

FINDING #3
CFDA Title: Medicaid
CFDA #: 93.778
Federal Award #: 05-0505ID5028
Program Year: October 1, 2004 to September 30, 2005
Federal Agency: Department of Health and Human Services
Compliance Requirement: E – Eligibility
Questioned Costs: Not determinable

Medicaid eligibility data in EPICS is still not reconciled to AIM.

We recommended in the fiscal year 2003 and 2005 audits that the Department establish a reconciliation process between EPICS and the Medicaid "AIM" payment system to ensure client eligibility was properly recorded and provider claims were paid promptly. This reconciliation process has not been fully developed, and the ongoing enhancements to the EPICS system are creating new variations and errors in client eligibility that are not actively identified or corrected.

The Department received additional funding in fiscal year 2007 to begin the process of replacing the EPICS eligibility system. This system has worked well over the years at processing and storing data, but was originally developed during the early 1980s and has been extensively modified over the past 25 years. The core software and system processes do not integrate well with current technology, and many other factors limit its overall functionality. In addition, staff training and quality control programs have been reduced or eliminated over the years. It is these conditions that create the opportunity for errors and the basis for seeking to enhance and replace the EPICS system.

We analyzed a small sample of 173 clients eligible in the EPICS system for June 2006, that did not have eligibility in the AIM system. We determined that 69 of these clients had an error in their EPICS record which delayed or prevented the record from being added to the AIM system. Without a record in AIM, clients do not receive a Medicaid card with access to services, and providers cannot receive payment for services.

Although our analysis was not statistically based, the quantity of errors indicates serious weaknesses in the processes and controls that ensure eligibility data is properly recorded. Hundreds of cases per month are corrected manually by the EPICS help desk employees who receive questions and complaints from regional caseworkers and others. However, there are no procedures in place to actively identify and correct errors in EPICS until a question or complaint is filed.

Efforts have not been taken to reconcile the eligibility data in the EPICS and AIM systems because the process is very labor intensive, and resources are directed toward other issues. The ongoing enhancements to the EPICS system are adding to the complexity, and no interim procedures exist to ensure the accuracy and integrity of the eligibility records. As a result, clients are not provided benefits promptly or at all,

while providers who render services to clients cannot be paid until the AIM record is created.

RECOMMENDATION #3

We recommend that the Department establish interim procedures to identify and correct errors in the automated records that cause client eligibility to be delayed or not established at all. These procedures should include actively identifying cases each month with characteristics known to cause eligibility errors and methods for documenting the changes made to the client record.

New issues will likely arise as the EPICS system enhancements continue, and these interim procedures should expand to minimize any future detrimental effect to clients and providers until all enhancements are fully operational.

CORRECTIVE ACTION PLAN

Upon reviewing the sample of cases reviewed by the auditor, we feel that the errors and issues identified either have been or will be addressed in the near future.

Problems related to the PW programming in EPICS will be eliminated. With Medicaid modernization, which was implemented in July 2006, the Division made programming and policy changes which eliminates this code in EPICS for children. Once all the cases are modernized to the new programming (anticipated for July 2007), we will significantly reduce many of the reconciliation issues between the EPICS and AIM system that are tied to this program code.

Related to instances of overlap in benefits, it is important to note that overlapping benefits is appropriate when you take someone from a restricted coverage group to a non-restrictive coverage group. Upon evaluation of the overlapping benefits identified through the audit, more than half of the cases cited actually had appropriate overlap because the individuals were moving to better coverage.

Other issues with clients being approved in EPICS but not passed correctly to AIM will be greatly reduced by consolidation of family related Medicaid into one unit for all maintenance. The staff in this unit manages only Medicaid cases. Specialization of the work will result in more correct entry of Medicaid information into the automated system

Finally, we have put processes in place to begin addressing those items that may still cause issues. We have implemented a process to immediately identify issues through the EDS system and send those issues to our EPICS Help Desk to be resolved. The EPICS Help Desk and the Division of Medicaid work to resolve those issues immediately. Other issues, which are primarily caused through keying errors and not system errors, will be identified through the Reconciliation Report which is expected to be implemented in May 2007. This report will identify all other reconciliation issues and provide an opportunity for the EPICS Help Desk and the Division of Medicaid to resolve any other outstanding or unidentified issues. The procedure to work the reconciliation report will include the EPICS Help desk actively identifying cases each month with characteristics known to cause eligibility errors and correcting errors appropriately where necessary.

FINDING #4

CFDA Title: Child Support Enforcement
CFDA #: 93.563
Federal Award #: G0504ID4004
Program Year: October 1, 2004 to September 30, 2005
Federal Agency: Department of Health and Human Services
Compliance Requirement: B – Allowable Costs
Questioned Costs: $499,000

Nearly $756,000 from the Child Support Grant was expended, in error, for services to ineligible clients.

Federal regulation (45 CFR 302.33) requires the Department to provide services to clients who are either required to cooperate with the Child Support Program as a condition of receiving assistance, or who applied for services and paid an application fee of $25. In 1998, new federal requirements were established (42 USC 654b) that require each state to operate a centralized receipting and disbursement unit. Costs for operating this unit are allowable to the grant, but only for those clients who meet eligibility requirements. Costs associated with providing services to clients who are not required to cooperate, or have not applied and paid a fee, are unallowable to the federal grant.

Cases where clients do not meet eligibility requirements are identified as "receipting services only," or RSO cases. The number of RSO cases identified by the Department as of June 2006, was 20,122 of the nearly 131,000 total cases in the ICSES automated child support management system. The Department identifies the cost of services to RSO cases based on a proportionate share of the automated case management system, receipting services contract, and related costs. The total cost for services to RSO cases during fiscal year 2006 was $1,154,000.

The Department transferred about $398,000 of these costs to the TANF federal grant, which we identified as unallowable to that grant in Finding 0F6-5. The remaining $756,000 was paid from the federal Child Support Grant, in error.

These cost errors were due partly to changes in staff and a misunderstanding of the requirements to exclude these costs from the federal grant. Our review indicates that the practice of claiming these costs to the federal grant has been in effect for at least the last three years.

RECOMMENDATION #4

We recommend that the Department exclude costs from the federal grant for child support cases where the client is not eligible for services. We also recommend that the Department resolve the fiscal year 2006 questioned costs with the federal grantor, and determine if adjustments for prior year claims that included these costs are required.

CORRECTIVE ACTION PLAN

The Department does not agree with this finding. We are following federal guidance from Audit recommendation #001009100 stating "TANF funds may be used for processing child support payments when the cases do not qualify for funding under the Child Support Enforcement program. Cases where the support order is on or after January 1, 1994, and the payment is made by wage withholding are eligible for funding by the Child Support Enforcement program. Older cases or cases where payment is not made by wage withholding may be charged to TANF." The Department also received guidance from ACF on 12/7/2000 stating TANF funds for processing and distribution can apply to court orders issued prior to 1994.

FINDING #5

CFDA Title: Temporary Assistance to Needy Families (TANF)
CFDA #: 93.558
Federal Award #: G0501IDTANF
Program Year: October 1, 2004 to September 30, 2005
Federal Agency: Department of Health and Human Services
Compliance Requirement: E – Eligibility
Questioned Costs: Not determinable

Documents were not available to support TANF eligibility in 60% of cases tested.

Federal regulation (45 CFR 263.2(b)) and Department rules (IDAPA 16.03.08) require the Department to obtain documents to support eligibility determination for cash assistance under the TANF program. These documents include a birth certificate, social security card, a personal responsibility contract, immunization record, and school attendance record if applicable.

During fiscal year 2006, the Department provided $3.7 million in TANF cash assistance to nearly 8,500 clients. We randomly selected 30 clients to test eligibility, and identified 18 (60%) where one or more required documents were missing from the case file. Most case files were missing two or more documents, with one file missing all five required documents.

There are financial penalties established in the Department's rules for families who fail to provide documents. For example, school attendance records are required for all children in the household, and a $50 penalty per month, per child, will be subtracted from the cash assistance if a child does not attend school. The lack of school records would indicate that penalties could be assessed; however, none of the nine cases in our sample that were missing these documents were penalized.

Our review indicated that some of the Department's regional offices use a standardized checklist to assist staff in identifying the required documents. Most of the errors were in regions where the checklist was not used, and this appears to be the common factor as the cause for missing documents.

RECOMMENDATION #5

We recommend that the Department review all TANF cases, and obtain any missing documentation to reassess whether eligibility and benefit amounts were properly determined. We also recommend that the Department develop a checklist to be used by all regional offices to ensure that all supporting documents are obtained before benefits are issued.

CORRECTIVE ACTION PLAN

TANF Legislative Findings

There were 30 cases reviewed statewide by the Legislative Auditor. Of those 30 cases, 18 cases were identified as having errors in categories: lack of school attendance records, lack of immunization records, lack of birth certificates, lack of SS cards, no PRC in file. In those 18 cases some cases had multiple findings. Listed below are findings and responses. Findings were based on a combination of TAFI rule, TAFI policy and keying in EPICS.

Lacks School Attendance Records

9 cited findings –

RESPONSE: There is no requirement in rule or policy that indicates school attendance records must be in the file. It is Department policy to verify school attendance when questionable and if the child is 16 years or older. All of the

cases that were identified for lack of school attendance were under 16 years of age. The Department does not see this as an issue.

Lacks Immunization Records
12 cited findings –
RESPONSE: There is no requirement in rule or policy indicating immunization records must be in the file or updated in the file. Re-documentation of immunization for school aged children is not necessary for TAFI purposes. Workers note the age of the child and determine if they are school age or not. The Department considers immunization for school age children verified by public school attendance. If a child is attending public schools, the child is required to provide immunization records to attend public schools; therefore, the Department does not require the family to re-verify this information. For pre-school age children we review their immunization records and accept them as complete, even when they may be behind the immunization schedule. Many children get behind and may never get caught up with the actual schedule for their age. Currently the approval of TAFI eligibility will not process without the immunization indicator keyed on the CLRE screen. The Department does not see this as an issue.

Lacks Birth Certificates
9 cited findings –
RESPONSE: TAFI eligibility requires relationship verification on adult applicants only and in caretaker grant cases between the caretaker and the child. The source of verification may be through the system or third party and is usually narrated. Birth certificates are not mandatory TAFI relationship verification. There is neither rule nor policy that states that a "Birth Certificate" must be in the file.

No PRC in File
5 cited findings –
RESPONSE: The Department contracts the TAFI case management for work eligible individuals with the EWS contractor. The contractor's files contain the PRC. These files are monitored by the Department CERM Team quarterly. Upon assessment of the reviews done by the auditor, it was validated that all files reviewed had a completed PRC in the file. The only PRC's that would be kept in a State file would be Ineligible Alien files. The five files cited in error were all work eligible individuals and were referred to the contractors for case management.

Lacks SS Cards
10 cited findings –
RESPONSE: The Department verifies SSN through State On Line Query (SOLQ) which is an interface with Social Security Administration. If the SSN given to the Department by the applicant clears (numidents) with Social Security Administration, the SSN is assumed to be valid and the system automatically enters an "N" on the EPICS CLRE screen. If the SSN is not cleared, an error message is received and the case will not process. The SSN is validated through interfaces and there is no requirement for documentation in the case file; in fact, it is against SSA policy that the screen prints from the SOLQ are in the case record. Due to current processes and verification standards in place, the Department does not feel this is an issue.

FINDING #6

CFDA Title: Temporary Assistance to Needy Families (TANF)
CFDA #: 93.558
Federal Award #: G0501IDTANF
Program Year: October 1, 2004 to September 30, 2005
Federal Agency: Department of Health and Human Services
Compliance Requirement: B – Allowable Costs
Questioned Costs: $4,590,000

TANF funds were used for Head Start, child support receipting, and other unallowable activities.

Activities funded by the Temporary Assistance to Needy Families (TANF) program must meet one of four broad objectives established in federal regulations (45 CFR 260.20). These objectives include providing assistance to needy families so that children can be cared for in their own home, promoting job preparation and marriage, reducing out-of-wedlock pregnancies, and encouraging the formation and maintenance of two-parent families.

The Department uses TANF funds to provide a variety of activities and services, some of which do not meet TANF objectives. For example, during fiscal year 2006, the following activities were paid with TANF funds:

1. $1,081,000 – Immunization Registry Information System (IRIS)
2. $100,000 – Poison control center hotline
3. $1,535,000 – Head Start for educational activities
4. $398,000 – Child support receipt processing costs
5. $1,476,000 – Governor's Coordinating Council for Families and Children for Suicide Prevention, Brightest Stars, and other activities

The federal grantor reviewed Idaho's TANF State Plan for fiscal year 2007, and has required that amounts allocated for the poison control hotline and immunization registry be removed because they do not meet TANF objectives. Our analysis showed a similar disconnect for the other listed activities. Educating preschool children, processing child support receipts, and preventing suicide, as well as several other costs within the Governor's Coordinating Council are not objectives of the TANF program and are unallowable to the grant.

If a state misuses TANF funds, the federal grantor can reduce the grant award by the amount misused, plus an additional 5% of the quarterly grant award, if the misuse is determined to be intentional (45 CFR 263.10).

RECOMMENDATION #6

We recommend that the Department evaluate all programs funded by the TANF grant to ensure that funds are used only for activities that specifically meet the federal objectives. We also recommend that the Department resolve the questioned cost amount with the federal grantor.

CORRECTIVE ACTION PLAN

FACS staff and Division of Welfare staff worked with Gayle Jost from the Regional TANF Office to evaluate use of TANF funds. The evaluation has been completed with Federal Partners and the results of that evaluation based on the review areas are described below:

Immunization and Poison Control

The funding of these programs has been reported in all past TANF Plans. At no time did the Federal ACF Federal Partners indicate that these expenditures were

inappropriate. With the submission of the TANF Plan in 2006, we were told by ACF that we could not use TANF funds for the Immunization Registry and Poison Control. As a result, those programs were removed from the plan submitted in 2006 and are no longer funded with TANF funds as of June 2006.

Head Start

Head Start is considered to be a legitimate use of TANF funds according to a discussion held with Region X TANF Federal Partners. Head start meets purpose 4, encouraging the formation of two-parent families and purpose 2, ending dependence of needy families on government benefits by promotion of job preparation, work and marriage. Head Start does not just provide educational services to children; it provides parenting, conflict resolution, and self-sufficiency services to the parents of children enrolled in the Head Start program.

Child Support Receipting Costs

Child Support Non-IV-D costs charged to TANF are legitimate. In 2000 a similar audit finding was answered by Region X staff in an e-mail dated December 2000.

> "Audit Resolution: TANF funds may be used for processing child support payments when the cases do not qualify for funding under the Child Support Enforcement program. Cases where the support order is on or after January 1, 1994, and the payment is made by wage withholding are eligible for funding by the Child Support Enforcement program. Older cases or cases where payment is not made by wage withholding may be charged to TANF. Based on the documentation you have provided, we accept your assurances that cases eligible for funding by the Child Support Enforcement program have been removed from TANF funding."

Also in that e-mail, the use of TANF funds for processing child support payments for Non-IV-D cases is appropriate per TANF funding guide page 12, item D, second paragraph, which reads: "some activities that are reasonably calculated to accomplish this purpose might include activities to promote parental access and visitation...." Given that the processing and distribution of child support payments can be reasonably considered to support parental access and the maintenance of parental involvement with their children, the State's argument about meeting the goal of purpose 4 is valid.

Governor's Coordinating Council for Families and Children for Suicide Prevention, Brightest Stars, and Other Activities

The Governor's Coordinating Council has supported the following activities which they believe will assist families and children and ensure self sufficiency:

1. The Early Care and Learning Initiative to focus on early care and learning across the State.
2. Parents as Teachers (PAT) program for early childhood parent education that serves families throughout pregnancy until their child enters kindergarten. PAT provides the information, support and encouragement parents need to help their children develop optimally during the crucial early years of life.
3. The GOC has been involved in a variety of programs in the areas of substance abuse prevention, including projects focused on underage drinking.

4. The GOC has supported the GCCFC task force on mental health and funded Red Flags suicide prevention training in schools and communities.
5. Community Collaboration Contracts (CCC) are awarded to community organizations through an annual competitive application process. Funding is awarded to projects demonstrating collaboration with a minimum of three non-profit, private, or public sector organizations working on a community project that will serve families and children.
6. The Governor's Roundtable Conferences provide annual training and capacity building.

FINDING #7

CFDA Title: Child Care and Development Block Grant
CFDA #: 93.575
Federal Award Number: G0401IDCCDF
Program Year: October 1, 2003 to April 30, 2006
Federal Agency: Department of Health and Human Services
Compliance Requirement: E – Eligibility
Questioned Costs: Not determinable

Client eligibility for child care assistance is not properly documented.

Federal regulation (45 CFR 98.20) and administrative rules (IDAPA 16.06.12) require the Department to obtain specific documents to support client eligibility for assistance under the Child Care and Development Block Grant program. These documents include a signed application declaring citizenship, proof of wages or verification of educational activities, a utility bill to prove residency, and a birth certificate or social security card if the age of the child or citizenship appears questionable. A record of the child's immunizations is also required.

During fiscal year 2006, the Department provided $31.2 million in direct child care assistance to 9,100 clients. We randomly selected 32 client files, representing 71 children, to determine whether eligibility for child care assistance was properly determined and documented. The results of our tests were as follows:

Citizenship was not indicated or documented.
The signed application form did not indicate that the child was a citizen in eight of 32 files reviewed (25%). No other evidence, such as a birth certificate, social security card, or other data was in the files to document citizenship for each child for whom benefits were provided. The reason for the incomplete application and missing documents is unclear, but the use of a checklist and improved supervisory review are possible remedies to this situation.

Progress reports were missing.
Clients who receive child care assistance for educational or training programs must provide verification of "satisfactory progress" in order to remain eligible for assistance. Two of the 32 client files we selected were involved in training programs, but neither one contained progress reports as required.

Immunization records were incomplete or missing.
Federal regulation (45 CFR 98.41(a)) requires that children who receive benefits are properly immunized for their age, in accordance with the State's schedule of immunizations. Our review showed that 21 of 71 children (30%) did not have an immunization record, and 10 of the remaining 50 children (20%) had an immunization record that was not

complete when compared with the State's schedule. The missing records related primarily to school-age children who likely had appropriate immunizations, but no evidence was in the files to support this. An annual review of immunization records is required, but these instances were apparently not discovered. The use of a checklist and improved supervisory review of these documents would also likely remedy this situation.

Exclusion of foster family income was not documented.
Administrative rule (16.06.12.202) allows the Department to exclude the income of foster families who apply for child care assistance on a case-by-case basis. Two of the 32 files we selected involved assistance to foster families, but neither one considered or documented the income of the foster parents or indicated why the amounts were excluded. Our sample of these types of cases was too small to draw specific conclusions. However, no guidance is provided to caseworkers on the issues to consider or the documentation required for excluding foster family income.

RECOMMENDATION #7

We recommend that the Department obtain appropriate documentation of eligibility for all clients receiving child care assistance. A checklist for staff should be considered to ensure all requirements are met, with additional training and supervisory reviews when cases are established and eligibility is redetermined.

CORRECTIVE ACTION PLAN

Citizenship Was Not Indicated or Documented
ICCP does not require that an ICCP recipient be a U.S. citizen. The recipient must be legally in the country or the child for whom the ICCP is being obtained must be a citizen. EPICS system information, Vital Statistics, and Social Security Administration interfaces are used to verify citizenship status for ICCP applicants. Federal programs such as Food Stamps and Medicaid have stringent federal citizenship requirements. The EPICS system information provides much of the necessary information to verify citizenship when the family is receiving Food Stamps and Medicaid. Therefore, when an ICCP applicant is receiving Food Stamp or Medicaid benefits, citizenship has been verified and rather than having the client re-verify the information for ICCP benefits, the Department uses the information recorded in EPICS as proof of citizenship. Vital Statistics provides information on when and where a child was born. ICCP has access to this interface and uses this information when appropriate. Numidented (or verified social security numbers) can be obtained through the State On-Line Query system (SOLQ) with the Social Security Administration which provides verification that the applicant is legally in the United States. It would be redundant to require all identity verifications again. In all cases reviewed system documentation exists in other Department programs that indicate citizenship is not an issue.

Progress Reports Were Missing
Four years ago, it was discovered that students who did not have satisfactory progress after one semester would not continue to receive financial aid. Students who receive ICCP have low enough incomes to receive financial aid. The continuance of financial aid provides verification of "satisfactory progress."

We are working to clarify the ICCP rules regarding evidence of satisfactory progress through proposed rule changes. Neither of these rule changes were approved by the legislature during the 2007 Legislative Session, but work is in progress to modify these rules and re-submit for approval.

Immunization Records Were Incomplete or Missing

Idaho considers immunization for school age children verified by public school attendance. If a child is attending public schools, the child is required to provide immunization records to attend public schools; therefore, Idaho does not require the family to re-verify this information with the State.

For pre-school age children we accept immunization records as complete, even when they may be behind the State schedule. Many children get behind on their immunizations and are never able to get caught up with the actual schedule for their age. According to our rules, child care payments can continue during a reasonable period necessary to comply with immunization standards.

In assessing the reviews completed by the auditor, eleven cases did not require immunization records on file because of the child's age or participation in the TAFI program. Nine records were incomplete, and we allowed them to remain on ICCP even though they were behind the State's schedule. Twelve cases were missing immunization records for one or more children.

Exclusion of Foster Family Income Not Documented

ICCP rule does not require that the reason for excluding income must be documented in the file. Finding and retaining qualified foster parents is a major priority for the Department of Health and Welfare, and therefore we try to minimize the impact of foster parenting as much as possible. We do look at excluding foster parent income on a case by case basis, but upon review of the two cases reviewed by the auditor, we found the income was properly excluded. The Division of Welfare does not want to be too specific in rule in creating parameters around when to exclude foster parent income, as we want to continue to assess this on a case by case basis.

Good, efficient customer service and case management is a goal of the Division of Welfare. Eliminating redundancies in eligibility determination is one way of achieving this goal. The Division will continue to identify interfaces, development and use of electronic case files, and standards for verification that will allow individuals to apply for services without having to produce actual paper documentation that we already have access to. With that said, there are some measures the Division will implement to ensure that the reason for making the case determination is clear. These measures include improve narration standards so that it is clear in the narrative what interfaces and sources have been used to establish citizenship status and immunization schedule.

The Division of Welfare is also modifying two ICCP rule proposals. Legislative approval and administrative implementation of these rule changes will eliminate some problems around foster care eligibility and evidence of "satisfactory progress."

FINDING #8

CFDA Title: Medicaid
CFDA #: 93.778
Federal Award #: 05-0505ID5028
Program Year: October 1, 2004 to September 30, 2005
Federal Agency: Department of Health and Human Services
Compliance Requirement: C – Cash Management
Questioned Costs: $145,000

Federal funds were drawn early, in error.

Each year the State of Idaho agrees to a variety of methods for drawing federal funds, as required by the federal Cash Management Improvement Act (CMIA). The objective of these methods is to minimize the time elapsing between the transfer of funds from the federal grantors and the actual disbursement of funds by the State.

The Department did not follow the agreed upon methods for drawing federal funds for several grant programs, the largest of which was the Medicaid program.

The method for drawing Medicaid federal funds is based on the timing of when amounts disbursed are actually redeemed by the State Treasurer's Office, identified as a "clearance pattern." The clearance pattern used by the Department for fiscal year 2006 was the "draft" pattern, and not the final version in the formal CMIA agreement. The difference between the draft and final version was significant, resulting in the Department drawing Medicaid federal funds early for the entire year. This created a potential interest liability to the federal grantor, estimated to be more than $145,000. The draft clearance pattern was also used to calculate the federal draws for several other grant programs, which could significantly increase the interest liability.

Other agreed upon draw methods are also not followed. For example, federal funds for the child care program were drawn once a week, yet the agreed upon method is to draw funds over a seven-day period. Cash assistance under the Temporary Assistance to Needy Families (TANF) program was drawn based on the benefit amounts authorized to clients, rather than when funds were actually disbursed. The potential interest liability is not material in these instances, but it indicates the need for a comprehensive review of all draw methods by the Department to ensure compliance with the CMIA agreement.

RECOMMENDATION #8

We recommend that the Department review the draw methods used for all federal grant programs to ensure compliance with the procedures identified in the CMIA agreement. We also recommend that the Department resolve the potential interest liability with the federal grantor.

CORRECTIVE ACTION PLAN

The Department has reviewed the final clearance pattern included in the CMIA agreement and found it does not correspond to the actual historic clearance pattern experienced by the Medicaid program. DFM has indicated they will review the clearance patterns with the Treasury to get the correct one in place. This should eliminate the interest liability. Other draw methods will be reviewed to bring them into compliance with the CMIA agreement.

FINDING #9
State Issue

Travel vouchers are not prepared as required by Idaho Code and State travel policies.

Idaho Code, Section 67-2006 requires employees to complete and sign a travel voucher to certify that expenses were necessary and appropriate. State travel policies also require each agency to maintain complete records and supporting documentation for all travel costs on forms provided by the State Controller's Office. If travel costs are paid for with a purchasing card, or "P-card," a complete accounting of these costs is required on the travel voucher form, including attaching appropriate receipts and invoices.

The Department does not require employees to complete travel vouchers if all costs are paid through other means, such as direct billed or P-card. We identified multiple instances of disconnected travel costs, such as hotel costs without any associated transportation or meal expenses. Without a travel voucher, no evidence is available to verify that travel costs were properly accounted for and complete, or that established requirements and limitations were met.

The potential for errors and overpayments is further increased because travel costs can be paid in several ways. For example, travel costs can be paid by direct billings from the vendor, P-card charge by the traveler or other staff, or reimbursed directly to the traveler on a travel voucher form. In some instances, travel costs are reimbursed by an outside source, such as a federal agency or association. The lack of a travel voucher makes it difficult to ensure that all costs are appropriate, or to establish links to all costs related to a trip and the source of funds used to pay these costs.

RECOMMENDATION #9

We recommend that the Department comply with Idaho Code and State policies by requiring travelers to prepare vouchers that identify the travel itinerary, all costs associated with the trip, and the method of payment. Travel vouchers should include all details of each trip, even if the traveler is not seeking any additional reimbursement.

CORRECTIVE ACTION PLAN

The Department has developed a new travel voucher that will consolidate all expenditures related to a trip in a single document regardless of disbursement process. The procedures for use of this document will require that it be filled out and submitted even when there are no funds due the traveler. This will provide the required trip purpose and document appropriateness and approval of the expenditures made. We plan to implement this new travel voucher for all trips made after April 1, 2007.

FINDING #10
State Issue

Internal controls and monitoring P-card usage needs improvement.

P-cards were issued to 626 Department employees during fiscal year 2006, who transacted nearly 40,000 transactions totaling $6.9 million. Internal controls have been established that limit the overall risks, but additional improvements in controls and usage are needed.

Second level approval not documented or properly established. Department P-card policies require a second approval for all transactions and states that "in no case may a second level approver approve transactions on his or her own card." However, we identified 613 transactions during fiscal year 2006, where the second level approval was blank, and 206 transactions that were approved by the cardholder in violation of Department policies. Second level approval provides a significant internal control, and these instances indicate a serious weakness in both the internal controls and the process used to establish approval levels in the P-card system.

Purchases do not follow statewide contract requirements. We identified P-card purchases for rental cars, office supplies, and other items available under open statewide contracts that were not purchased from the contract vendors as required by Idaho Code, Section 67-5726(4). This code requires that "no officer or employee shall fail to utilize an open contract without justifiable cause for such action." These purchases tend to dilute the benefits of the statewide contracting process.

Sales taxes paid in error. Idaho Code, Section 63-3622(O)(f) exempts State agencies from paying Idaho sales tax, yet nearly 25% of P-card users had one or more transactions where sales tax was paid. Several P-card users made an effort to inform vendors of the tax-exempt status, but overall the effort to avoid paying sales tax appears to be haphazard.

RECOMMENDATION #10

We recommend that the Department strengthen internal controls and monitoring over P-card transactions by properly assigning second level approvals for all users, and notifying staff to use statewide contract vendors and avoid paying State sales tax. We also recommend that the Department periodically monitor approval levels and transactions to ensure controls and usage are appropriate.

CORRECTIVE ACTION PLAN

Second Level Approver

System changes were made by the State Controller's Office to not allow a user to approve transactions initiated by same person. We have also reviewed assigned second level approvers with program staff to ensure the person assigned properly completes the process and documents this in the P-Card system. Third level approvers have been instructed to not approve transactions without proper second level action.

Purchases Do Not Follow Statewide Contract Requirements and Sales Taxes Paid in Error

A letter has been sent to all P-card users reminding them of the required purchasing procedures and to review transactions for sales tax inclusion before approving the transactions. Any exceptions to this process will require documentation to be submitted with the P-card transmittal. This will also be reinforced to second and third level approvers to check to see that proper procedures have been followed.

PRIOR FINDINGS AND RECOMMENDATIONS. The prior audit report for fiscal year 2005 included 13 findings and recommendations. Following is the status of those findings and recommendations.

PRIOR FINDING #1

Changes are needed in the criteria used to establish Medicaid eligibility under the Katie Beckett program.

We recommended that the Department undertake a thorough review of the criteria used to determine eligibility in the Katie Beckett program, and establish processes to monitor services provided to clients to ensure that an appropriate level of care is provided.

DEPARTMENT'S ORIGINAL RESPONSE

The Department believes that all Katie Beckett clients are eligible according to federal rules and the State Plan. They disagree that the Department should monitor all services provided for Katie Beckett clients. They acknowledge however, that the number of clients could be decreased by making the criteria stricter.

STATUS – CLOSED

The Department has developed and implemented additional review steps to strengthen the eligibility process and verify institutional level of care. The federal grantor has agreed that these additional steps will result in the needed oversight of the Katie Beckett Program and has cleared and closed this finding.

PRIOR FINDING #2

Idaho is one of only two states without a certified Medicaid Fraud Control Unit (MFCU).

We recommended that the Department initiate a dialog with executive and legislative leadership to evaluate the merits of establishing a certified MFCU that could provide additional funding for investigating and prosecuting suspected cases of Medicaid fraud and patient abuse. We suggested that this dialog include the State Attorney General.

DEPARTMENT'S ORIGINAL RESPONSE

The Department recognizes the need to add additional resources for fraud investigations and agrees to participate in evaluating the need for a certified MFCU. However, they disagree that a MFCU would lead to financial benefit or increased investigations and recoveries. The Department believes that the decision to establish an independent MFCU is a policy decision for the legislature, the Governor's office, and Department heads.

STATUS – CLOSED

Legislation was passed during the fiscal year 2007 legislative session (HB 166) that established a certified Medicaid Fraud Control Unit within the Idaho Attorney General's Office, effective July 1, 2007.

PRIOR FINDING #3

The process for identifying and recording private health insurance coverage of Medicaid clients needs improvement.

We recommended that the Department improve the processes and efforts to identify and record health insurance resources of Medicaid clients as follows:

1. **Develop a retrospective review process for suspect claims in order to identify insurance resources known by providers previously excluded from the process.**
2. **Amend the contract to define a valid insurance resource as one where the coverage period overlaps the client's period of Medicaid eligibility. The Department should analyze all insurance resources added during the last year, and request a refund from the contractor for fees to add resources for clients who were not eligible during the insurance coverage period.**
3. **Coordinate the establishment of an enhanced data match process with Idaho-based private insurance companies to improve the efforts to identify Medicaid clients having health insurance. This may require the assistance of the Idaho Department of Insurance and legislation to establish the Department's ability to access this data.**

DEPARTMENT'S ORIGINAL RESPONSE

The Department disagreed that insurance data is not pursued. They believe that insurance resources recorded do avoid cost or lead to recoveries. The Department is researching other states' laws regarding comprehensive insurance data.

STATUS – CLOSED

The Department has revised its contract with its third-party recovery contractor, and the contractor has strengthened processes to ensure insurance is pursued and costs are appropriately avoided.

PRIOR FINDING #4

Medicaid eligibility continues to be improperly determined, due primarily to the outdated automated system.

We recommended that the Department identify the processes and issues that cause Medicaid eligibility to be improperly determined. Corrective action was also needed to address payment processing errors reported in the Payment Error Rate Measurement Report. We also recommended that the Department continue to seek resources to replace EPICS.

DEPARTMENT'S ORIGINAL RESPONSE

The Department has taken steps to improve the quality and timeliness of Medicaid eligibility determinations. Modifications have been made in the EPICS system that will allow workers to more accurately select the correct coverage group for applicants. Modifications go into effect in April 2006 to renewal processing in the automated system.

STATUS – CLOSED

The Department has completed all of the corrective actions from the original response. The EPICS system modifications were made, the Medicaid waiver is being implemented, and the replacement of EPICS system has begun.

PRIOR FINDING #5

Essential edits in the Medicaid claims payment system are disabled and allow claims to be paid in error.

We recommended that the Department enable all essential system edits to ensure the accuracy of claims paid, and ensure that Medicaid is the payor of last resort when claims relating to injuries or accidents are submitted.

DEPARTMENT'S ORIGINAL RESPONSE

For the following reasons, the Department disagreed that essential edits were disabled.

1. The edit that matches a client's name and number to Medicaid records was in test in January and February 2005, to determine the most effective way to handle mismatches. However, it was turned on March 1, 2005, and has been in place since that time.
2. The edit that checks for "injury accident" claims is active. These claims are automatically "pended" for further review except for Medicare claims which the Department is federally mandated to pay as submitted.

STATUS - CLOSED

The Department has taken steps to apply the "name number mismatch" edit to cross-over claims from Medicare. These cross-over claims were not previously subjected to this edit and are the bulk of items identified in the audit.

PRIOR FINDING #6

The Healthy Connections Medicaid program is not cost effective for at least two of four eligibility groups.

We recommended that the Department reevaluate the Healthy Connections waiver and discontinue this program, or consider incorporating it into the State Plan to eliminate the need to justify cost effectiveness and eliminate the potential refund of program costs to the federal grantor.

DEPARTMENT'S ORIGINAL RESPONSE

The Department has undertaken a significant Medicaid reform effort that began in July 2006. The Healthy Connections program will no longer be a separate waiver and will be incorporated into the new State Plan.

STATUS - CLOSED

The Department submitted an amendment to incorporate the Healthy Connections program into the State Plan effective no later than October 2006.

PRIOR FINDING #7

Efforts by the Child Support Program to recover Medicaid birth costs are not consistent.

We recommended that the Department pursue birth costs from all biological parents who are not included on the application for Medicaid assistance. Child support cases should be established for

all clients and the reasons documented for not pursuing birth costs where appropriate.

DEPARTMENT'S ORIGINAL RESPONSE

The Department's Medicaid Division is reviewing this issue with program experts and the Deputy Attorney General, and will present options to director.

STATUS - CLOSED

This issue is repeated as Finding #1 in the current findings and recommendations section.

PRIOR FINDING #8

The number of child support cases with debt errors has declined but remains high.

We recommended that the Department enhance the efforts to review and correct child support debts. The Department should continue to pursue additional resources to address this issue in order to complete this effort within a reasonable timeframe, perhaps within the next two to three years.

DEPARTMENT'S ORIGINAL RESPONSE

The Department will continue to work on improving the accuracy of child support debt balances by auditing approximately 400 cases per month. The Department requested an additional $3.1 million in fiscal year 2006 to address this issue that the legislature did not fund. A similar request was made for fiscal year 2007 that was not approved by the Governor.

STATUS - CLOSED

The Department has made substantial improvements in the Child Support Program by consolidating and standardizing case work processes. New units have been established to perform financial audits and reviews, and to monitor performance on a regular basis to ensure that cases have accurate financial records.

PRIOR FINDING #9

Child care benefits are calculated on market rates and poverty tables that are more than five years old.

We recommended that the Department base the child care benefit calculation on current market rate surveys and federal poverty rates as required by administrative rule. Efforts to manage the growth in program costs should rely on appropriate processes to adjust administrative rules or other factors used to determine benefit amounts and client eligibility.

DEPARTMENT'S ORIGINAL RESPONSE

The Department disagreed that administrative rules require the use of current market surveys and poverty limits in calculating child care benefits. There is no federal mandate that the poverty limits are adjusted annually.

Raising the poverty rate to the current amount would result in an estimated increase in benefit costs of $2 million. Raising the market rate would likewise increase benefit costs by $1.5 million. The

Department is currently considering raising the market rate and using the current poverty limits within the existing budget.

STATUS – CLOSED

The Department will propose two rule changes to the Idaho Child Care Program during the next legislative session. These changes are expected to generate a savings that will allow current market rates and poverty tables to be used.

These rule changes will limit student eligibility by establishing a work requirement and reduce the period of time in which a post-secondary student can receive benefits.

PRIOR FINDING #10

Funds from the Temporary Assistance to Needy Families (TANF) grant are used for medical costs, foster care services, and other unallowable activities.

We recommended that the Department review all foster care costs paid with TANF funds to identify the amounts allowable under prior law, and amend the federal quarterly reports for the past year to accurately reflect the amounts. The Department should amend the current TANF State Plan to clarify the circumstances for which foster care costs are allowable for funding and develop new coding structure to properly report these costs in the future.

We also recommended that the Department reaffirm with staff the requirements for documenting family income and emergency conditions when authorizing services using TANF funds, and return $2,056 to the federal grantor for medical costs charged to the TANF grant in error.

DEPARTMENT'S ORIGINAL RESPONSE

The Department agrees that medical costs of $2,056 were unallowable, and these funds have been returned to the federal grantor. The Department will amend the TANF State Plan to fully identify the use of program services allowable under the 1993 State Plan, and describe the circumstances when foster care costs can be paid with TANF funds. In addition, the Department will reinforce the need to switch funding for foster care services promptly to sources other than TANF once the client has been determined eligible for Foster Care Grant program services.

The Department agrees that emergency assistance funds were used improperly, and will provide training related to this issue to all staff involved in the emergency assistance program.

STATUS – CLOSED

The Department has completed all of the corrective actions described in it's original response.

PRIOR FINDING #11

Food stamp error rate continues to exceed the allowed percentage and will result in additional financial sanctions.

We recommended that the Department improve the accuracy of the eligibility process to reduce payment error and negative error rates to avoid additional sanctions and the consequences to needy families who are denied assistance in error. A renewed effort should be considered to seek funding to replace the outdated "EPICS" eligibility system.

DEPARTMENT'S ORIGINAL RESPONSE

The Department's corrective action plan to further reduce the error rate is a three pronged approach.

1. To realize immediate results, the Division is reviewing all cases with benefits exceeding $300 prior to the release of these benefits. This activity was selected in federal fiscal year 2005, 41% of all errors were in cases with benefits exceeding $300. This activity is being funded by a reinvestment of the sanction.
2. To achieve mid- and long-term sustainable improvements, the Division is taking specific steps to reengineer the business processes and food stamp policy to improve the initial application and application for recertification functions.
3. The quality assurance data indicates that 60% of the errors occur in these two functions. To achieve long-term sustainable improvements, the Department now has funding and is reengineering and replacing the EPICS system.

STATUS - CLOSED

The Department has completed most of the corrective actions and reduced the error rate to within a 0.2% of the national average for federal fiscal year 2005. Efforts are continuing to further reduce the error rate and seek additional funding to complete these efforts and replace the EPICS system.

PRIOR FINDING #12

Fees for mental health services are based on poverty rates that are more than 13 years old.

We recommended that the Department adjust the fees listed in the Community Mental Health Services administrative rules to current rates and federal poverty guidelines. We also recommended that the Department consider amending these rules to describe the method for determining the fees, rather than detailed values or fixed amounts, as a way to avoid the need for future amendments.

DEPARTMENT'S ORIGINAL RESPONSE

The Department will seek to change the rule so that it describes the scale method and refers to the current federal poverty limits. The rule change will exclude the detailed fixed prices for services that are covered under Medicaid and make reference to the Medicaid fee schedule. The Department will also update all fees not addressed by Medicaid.

This rule change will require a parallel change in the "Fees for Developmental Disabilities Services" as it uses the same poverty rates, sliding fee scale, and billing system as the Adult Mental Health Program. There may also be an impact to the "Rules Governing Family and Children's Services" that identifies fees for children's mental health services and includes the use of a sliding fee scale, based on 1998 poverty rates.

STATUS - OPEN

The Department is currently evaluating the most equitable way to update and use the same schedule for all Behavioral Health Programs. Once that is determined, the Department will promulgate rules to implement the change.

PRIOR FINDING #13

Administrative rules for recovering certain types of Medicaid costs from parents are not enforced.

We recommended that the Department undertake a complete analysis of the legal and legislative requirements for recovering certain Medicaid costs from parents. This analysis should seek to resolve the issues of whether to amend or delete these rules, appeal the District Court's ruling, or request legislation to clarify the intentions or authority to recover these costs from parents.

DEPARTMENT'S ORIGINAL RESPONSE

The Department has analyzed this issue in conjunction with the Deputy Attorney General and plans to review the statutory, legal, and administrative issues during the coming months to determine the appropriate resolution.

STATUS - CLOSED

The Department has rewritten these rules and deleted the requirement to recover certain Medicaid costs from parents, effective July 1, 2006. The revised rules will go before the legislature in 2007.

STATUS OF AUDIT FINDINGS PRIOR TO FY 2005

04F-1

The Department improperly used more than $1.8 million of the Temporary Assistance to Needy Families (TANF) Grant funds for inpatient treatment costs and child care services. Federal funding under the TANF program is available for a variety of services to clients, if certain eligibility criteria are met. These criteria establish income guidelines and job search and work requirements the client must agree to as conditions for receiving assistance.

Federal regulation (45 CFR 233.145 (c)) prohibits the use of TANF funds for medical services for any type of "remedial care provided by an institution to any individual as an inpatient." In addition, the Department's federally approved State Plan and the associated administrative rules (IDAPA 16.03.08.376) prohibit the use of TANF funds for any type of child care.

An analysis of costs charged to the TANF Grant during fiscal year 2004 disclosed the following:

1. Inpatient services in the amount of $358,000 were incorrectly charged to the TANF program. The Department used TANF funds to provide services to children in group residential and mental health treatment facilities. These inpatient services included medical services, based on reviews of vendor invoices, that provided diagnosis and other information. These costs were unallowable to the TANF Grant, even if a portion of the costs were associated with room and board.
2. Child care costs of nearly $1.5 million were charged to the TANF program in error. Near the end of federal fiscal year 2003, the Department determined that expenditures in the child care program would exceed available funding. As such, child care costs of $1,473,578 processed through the Idaho Child Care Program (ICCP) automated system during August and September 2003 were redirected to the TANF Grant. This was done by adjusting the accounting system coding and did not involve any client-level determination or other processes to document eligibility. As a result, nearly $1.5 million of the TANF funds were used improperly, which could result in financial sanctions or refund to the federal grantor.

We recommended that the Department comply with federal regulations by not charging medical services or child care costs to the TANF Grant. Program staff should be notified that residential treatment placements that include any medical services are not allowable costs to the TANF program. We also recommended that the Department contact the federal grantor to resolve the questioned costs and potential refund of federal funds.

STATUS – OPEN

Inpatient Treatment Costs. The Department is waiting for a final determination by the federal grantors as to whether inpatient costs and child care costs were made in accordance with federal rules and the State Plan.

Child Care Costs. In December 2005, the federal grantor reviewed the audit finding, and the Department anticipates receiving a written determination regarding questioned costs in the near future. The grantor also provided State Plan guidance to clarify use of TANF funds for child care. The State updated the TANF plan accordingly. The Division of Welfare and the Division of Management Services developed a better method for paying qualified child care services from TANF funds and prevent future questions.

04F-2

No procedures existed to identify or pursue child support debts from the estates of deceased non-custodial parents. Federal regulation (45 CFR 303.6) requires the Department's child support enforcement program to take "any appropriate enforcement action" necessary to pursue and collect court-ordered amounts from non-custodial parents. A variety of methods and processes have been established by the

Department to collect funds, including wage withholding, income tax refund offsets, and property liens.

One enforcement area not developed is pursuing the estates of deceased non-custodial parents. During fiscal year 2004, more than 230 cases were closed because the non-custodial parent died, but no efforts were taken to pursue the estate. In many cases, existing liens were released and efforts to collect from other sources were halted. We estimate that more than $1 million in court-ordered debts were written off, including more than $150,000 in debts owed to the State.

The child support procedures manual does not include any procedures for identifying or pursing the estates of deceased non-custodial parents. Caseworkers generally determine that a non-custodial parent has died by reviewing the local newspaper obituaries or from information provided by individuals involved in the case. Data from Vital Statistics and the Social Security Administration is available but may take several months after the date of death before it is provided to the caseworker.

The Department currently has an estate recovery program in place for the Medicaid program, which could be used to pursue the estates of deceased non-custodial parents.

We recommended that the Department develop procedures for pursing child support debts from the estates of deceased non-custodial parents through probate or other means. The Department should consider combining these efforts with the existing estate and probate recovery activities in the Medicaid program.

STATUS – OPEN

The Department is pursuing changes to its policy and seeking additional staffing to resolve this issue. The Division of Welfare and Medicaid are currently evaluating how best to coordinate estate and recovery activities.

04F-4

Eligibility continued to be improperly determined in one-third of the Children's Health Insurance Program (CHIP) clients tested. The fiscal year 2001 audit report disclosed that 25% of children enrolled in CHIP did not meet all eligibility requirements. The fiscal year 2003 audit report followed up on this issue and disclosed that errors continued to exist at nearly the same rate. Efforts were taken by the Department to modify the Eligibility Program Information Computer System (EPICS) and perform case reviews, resulting in a reduction in the number of clients enrolled in CHIP from 12,106 at June 2002 to 10,704 at June 2003. Total clients enrolled as of June 2004 were 12,046.

The audit showed that errors in determining eligibility continued to exist. A test of 30 randomly selected clients enrolled during June 2004 showed that 10 (33%) were not eligible for CHIP. Most of the errors were the result of miscounting income or resources, with some cases

containing more than one error, such as excess income and having private insurance in force at the time of application.

A comparison of all 12,046 clients enrolled in CHIP in June 2004, with client health insurance coverage known by the Medicaid AIM system, showed that 1,239 (10.3%) had some form of health insurance coverage in force during the month. In nearly all cases, insurance data existed at the time of application or at the annual redetermination date but was not considered in determining eligibility.

Most errors were the result of increasing case loads, declines in resources and staffing, and the use of outdated automated systems. Although the number of clients served from month to month appeared to have leveled off, this comparison did not reveal the actual volume of work performed. Additionally, there were no system edits in either EPICS or the Medicaid claim payment system to identify CHIP clients who had health insurance resources. Policies were not in place to direct staff to search for insurance coverage in the Medicaid system at the time of application or during the annual redetermination.

Proper eligibility determination is crucial in providing CHIP benefits to only those in need. These errors could result in the repayment of more than $4 million to the federal grantor for the federal share of CHIP benefits provided to ineligible clients.

We again recommended that the Department review case files and remove ineligible clients from CHIP. Additional resources and renewed efforts are also needed to develop new automated systems and processes to limit the opportunity for recurring eligibility errors.

We also recommended that the Department negotiate a resolution with the federal grantor concerning the potential refund for the cost of providing services to ineligible clients.

STATUS – OPEN

The Division of Welfare has filled 26 newly approved positions and planned to hire 9 more positions in January 2006, in accordance with the plan approved by the Legislature. Of the 26 positions hired, 11 were allocated to create the Family Medicaid Consolidated Unit.

Pending the outcome of an evaluation period currently underway, the Family Medicaid Consolidated Unit may eventually handle all "Medicaid only" applications, redeterminations, and eligibility for the entire State. During this pilot period, accuracy and time lines will be evaluated. A determination will then be made regarding movement of other cases into the unit.

Improvements to EPICS were made in May 2005, which allowed easy identification of individuals approved for CHIP, by who appears to be Title XIX eligible. Alerts are generated that allow staff to make corrections quickly.

The questioned cost amount has not yet been resolved with the federal grantor.

04F-6

The Department had not taken steps to pursue absent parents for reimbursement of ongoing Medicaid costs. Federal regulation (42 CFR 433.138) requires the Department to seek reimbursement of Medicaid costs from all liable third parties. A liable third party is defined by federal regulation (42 CFR 433.136) as "any individual, entity or program that is or may be liable to pay all or part of the expenditures" for medical assistance furnished under the Medicaid program.

The fiscal year 2002 legislative audit recommended that the Department take steps to develop and implement a strategy to pursue and recover Medicaid costs from absent parents. However, as of January 2005, no efforts have been made to pursue absent parents for ongoing Medicaid costs.

The regulations specify the actions to be taken, and require the Department to identify the paternity of all children receiving assistance and obtain data about the absent parent and their employer in order to recover the costs of services provided. Efforts to identify paternity and employer data can be coordinated with the child support enforcement program. However, the regulations clearly establish the Medicaid program's responsibility to identify all absent parents and other liable third parties, since many clients are not served by the Child Support Program.

Administrative rules (IDAPA 16.03.09.031) further reinforce this issue by directing the Department to "recover payments for medical expenses from any liable third party, including a parent."

The legal responsibility and location of absent parents are known for most of the 25,000 cases that have an existing court order for child support. If only 10% of these cases were pursued, the Department could recover more than $6 million in Medicaid costs and possibly reduce future costs by encouraging absent parents to insure their children rather than risk potentially large recoveries. The effort to pursue absent parents may require additional resources that could be offset by the recoveries generated by this effort.

We recommended that the Department develop a strategy to pursue and recover Medicaid costs from absent parents. This strategy should include methods for identifying all absent parents and opportunities to incorporate the Department's existing efforts and information in pursing these individuals.

STATUS – OPEN

The Department consulted with federal officials about the authority to designate an absent parent as a liable third-party resource. The Department is still waiting to receive guidance from the Center of Medicare and Medicaid Services (MBS) on this issue.